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**Fixing the broken image of care homes, could a 'care home innovation centre' be the answer?**

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**Abstract:**

Current workforces are not prepared for the increasing frailty of older people in care homes and their complex needs, Palliative care is now 'core' to the work of all care homes, Innovation is necessary to increase the attractiveness of a career pathway in the care of frail older people in care homes., We propose a 'care home innovation centre for training and research' to develop this complex area of care across a region?

Key words: innovation, teaching/research-based care homes, dementia, health and social care partnerships, older people

## **Fixing the broken image of care homes, could a ‘care home innovation centre’ be the answer?**

In an article in the Times in 2015, Janice Turner poses the question ‘who has a radical vision to fix the broken image of UK care homes?’ She had been reading Atul Gawande’s now celebrated book ‘Being Mortal’ in which he calls into question the system of care for frail older people no longer able to live in their own homes [1].

This commentary sets out one such radical vision for this complex situation: the concept of a ‘Care Home Innovation Centre’ (CHIC) to showcase excellence in care, to develop and deliver specialist care home training and to promote research and quality improvement initiatives (Box 1).

Box 1 – here

### **Why is change needed?**

Over the last five years, UK care home beds for older people have increased by a further 4% to 487,000 [2] – three times the number of all acute NHS beds [3]. Projections of current demographic trends suggest spending on long-term care provision will need to rise from 0.6% of our Gross Domestic Product (GDP) in 2002 by up to 0.96% by 2031 [4].

Current health/social care policy aims to support older people to live and die at home. Consequently, those who require admission to care homes are now much frailer and commonly have advanced progressive illnesses including dementia.

[5]. In a recent study of 2,444 deceased nursing care home residents, the mean number of recorded diagnoses per resident were four, with 45% of residents having dementia and a further 31% cognitive impairment [6]. Whilst two thirds of people living with dementia live at home, increasing numbers in the UK die in care homes [7]; however, place of death for those with dementia varies significantly internationally. For the countries where care homes are the commonest location, place of death varies from 48.9% to 93.1%, indicating the potential for modifying meaningful outcomes for adults with dementia [8].

Currently, a fifth of the UK population die in care homes [9] where most staff have limited healthcare training. Current support for the provision of end-of-life care is highly varied [10] and contrasts starkly with the multidisciplinary care available to 5.6% of the population who die in a hospice [11].

Although the UK has many excellent care homes which provide high-quality care for their residents, across the sector there is a significant need for improvement. The Care Quality Commission and the Care Inspectorate inspect and regulate UK care homes, evaluating them on safety, effectiveness, caring, responsiveness and leadership [12]. Although the majority of care homes receive a rating of 'good', still significant numbers identified are requiring improvement or inadequate [12, 13]. Such findings resonate with the public perceptions of long-term care as a negative choice, to be avoided wherever possible [14]. In common with the findings of the Burstow Commission, we are optimistic about the potential for change in the care sector and the need to value the role of care homes in delivering specialist care which cannot be provided in other settings [14].

However, a particular challenge is the recruitment and retention of staff. The care

home workforce is 'overlooked' compared to their NHS counterparts, with a lack of career structure and training opportunities [15]. A need to ensure access to training, particularly for the complex and specialised care required for the care home population, is now accepted [15]. Care home managers are a further professional group whose role often externally lacks definition and whose perspectives are often not included in research conducted in the sector [16].

In the UK, routine medical care for care home residents is provided by general practitioners (GPs). However, the provision of this care is heterogeneous, reflecting the challenges of cross-sector working and the legacy of innovations and different regional models of care [3]. There is inequity of access to specialist services including geriatric medicine, old age psychiatry and dentistry [3]. Relational working has been identified as central to the delivery of effective healthcare for UK care home residents, with the role of co-design and joint priority setting both an integral part of effecting change [17].

### **Teaching/research-based care homes:**

Teaching nursing homes are not a new concept in the international literature [18]. The key components are of quality patient care, reducing unnecessary hospitalisations, increasing knowledge and education in caring for residents, provision of experiential training for students, and conducting research to reduce the gap between theory and practice [19, 20]. This model can enhance care for residents and also for care providers. The essence of the model is the linking of the separate spheres of research, clinical care, education and training [19]. Success requires: ensuring adequate resource is available; making sure training does not detract from care; and recognizing the different cultures in delivery of

healthcare, social care and education [20].

'The Green House' (GH) model [21] developed in the USA provides other transferable learning to inform our concept. GH homes accommodate up to ten residents in private bedroom and bathroom facilities with communal shared living space. The care staff provide a diverse range of support for the residents, supported by visiting clinical teams. In this model the emphasis is on the promotion of quality of life, rather than a focus of health care needs. This brought reductions in hospitalisations and improvements in some quality markers of care [22]. However, performance metric-derived improvements were not uniform across homes, indicating that standards of practice are not guaranteed by the presence of an overarching care ethos alone [23].

### **Our vision and anticipated challenges**

Our vision for a 'Care Home Innovation Centre' is one partnered with the local community, acute hospitals, universities, hospices and, the care home sector and its regulators across a region.

The vision incorporates the core components of a teaching nursing home described earlier [19, 20] with training opportunities for care home staff in the region in addition to undergraduate and postgraduate students in medicine, nursing, and the allied health professions. It is closely aligned with needs identified in the UK-specific 'Quest for Quality' [24]. The vision includes establishing greater connections to the wider community to enable residents to live well, despite multiple co-morbidities. The importance of meaningful relationships will be integral to the care culture.

The vision will showcase a joint health/social care managed venture with associated funding (likely to require additional support from benefactors). With the current demographic projections and need for greater age-appropriate health care [25], we believe this is a timely vision for improved relational working within health and social care.

Identifying areas for improvement within the care home sector is not difficult. The challenge comes in establishing how to implement change [26]. The vision is for a new organisation that has the advantage in lacking 'established practice'. However, we recognize that establishing the CHIC will not effect wider change without working with the existing organisations and providers in the region. So that the benefits have the potential to reach beyond the individuals within the CHIC a 'hub and spoke model' is proposed (Box 1). This will link the CHIC to satellite care homes locally, who will have access to training and who will be supported to work together to develop quality improvement initiatives, directed by their own residents and staff.

Evaluating the success of the CHIC requires a multicomponent strategy. A key challenge is in ensuring we identify and measure outcomes important to residents and their family, managers and professional carers. This requires both a commitment of time from stakeholders to allow for practice to change before evaluation, as well as the use of appropriate metrics to measure success. The centre will have to attain the standards established by the regulatory bodies with respect to care quality and education. Evidence will be collected to quantify community engagement in the CHIC and other care homes in the region. Research success will be evaluated by securing funding, developing



collaborations locally and internationally.

Key aspects of our feasibility study include exploring existing local practice, previous innovations, staffing models, funding and professional perspectives. This is to help explore the impact the CHIC may have and help build a team to ensure sustainability beyond project delivery. As with any innovation, there may be unintended effects and our feasibility approach seeks to mitigate these before finalising the CHIC concept.

### **The Way Forward**

We are currently undertaking a feasibility study to clarify the practical implications of the CHIC across a region in South East Scotland which has 107 care homes and a population of 849,000.

As of 1st of April 2016, health and social care are integrated under statute in Scotland [27]. Although it is too soon to evaluate, this is a bold national move to facilitate innovations in integrated care. We foresee an opportunity for a local health and social care joint board to establish the CHIC.

The feasibility study, along with a financial assessment, is led by a steering group which includes geriatricians, regulators, old-age psychiatrists, GPs, nurse/clinical academics, social care, users and representatives from independent care home organisations. It will be completed by early 2017.

In conclusion, the modern hospice movement brought a 'sea change' in end-of-life care through teaching/research-based hospices with the emphasis on quality

of life and the creation of the new specialty of palliative care. Our CHIC has the potential to bring a similar radical improvement by reinvigorating long-term care provision for frail older people, raising the profile of the care home workforce, delivering resident-centered research, promoting recruitment and encouraging professionals to take a career in this vital area of care. Such a vision has the potential to help change the culture and image of care homes, and start to address the huge public health issue we face in the provision of 24-hour care of the oldest old.

**Key points:**

- Current workforces caring for people in care homes are poorly prepared for the complexity of care home resident needs
- Innovation is necessary to increase the attractiveness of a career pathway in the care of frail older people in care homes.
- Could a 'care home innovation centre for training and research' catalyse and help prioritise this complex area of care across a region?

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### **Box 1: Core aims of a Care Home Innovation Centre**

- To provide a high quality, innovative service for frail older people requiring 24-hour care, including care for people with advanced dementia and those at the very end of life in order to showcase expert physical, psycho-social and spiritual care.
- To provide specialist training for care home staff across the region through a 'hub and spoke' model
- To coordinate multidisciplinary community-based training in long-term care for students and professionals in medicine, dentistry, nursing and social work and other health professions including pharmacists, dieticians, physiotherapists, and occupational therapists
- To be a Centre for practice-based research and quality improvement initiatives in collaboration with other care homes within the region and local hospitals
- To be a Centre which is part of a local community engaging with and training people to volunteer in care home work; to give wider support to families caring for frail older people living at home; to provide both 'on-site' respite as well as 'at home' respite care